

State of Montana
Department of Public Health and Human Services
Quality Assurance Division

**FAMILY /GROUP DAY CARE
NEW PROVIDER APPLICATION CHECKLIST**

PLEASE ATTACH:

- ☐ **New Application Form** (must be completed in full, signed, dated, and notarized)
- ☐ **W-9 Tax ID Form** (Please submit 2 copies)
- ☐ **Insurance Verification Form** (Must be completed and signed by Insurance Agent)
- ☐ Current Public Liability Insurance ☐ Current Fire Insurance
- ☐ **Activity Schedule / Written Plan**
- ☐ **Sample Weekly Menu**
- ☐ **Floor Plan / Square Footage Report**
- ☐ **Release of Information** (must be completed in full, signed, dated, and notarized)
- ☐ Yourself ☐ Your Spouse ☐ Any Additional Workers
- ☐ Any One Else Living In The House Age 18 or Over
- ☐ **Statement of Health** (must be completed in full, signed, and dated)
- ☐ Yourself ☐ Your Spouse ☐ Any Additional Workers
- ☐ Any One Else Living in the House Age 18 or Over
- ☐ **Immunization Records** (MMR-Measles, Mumps, Rubella; Td-Tetanus Diphtheria – See Page 2 of Application)
- ☐ Yourself ☐ Your Spouse ☐ Any Additional Workers
- ☐ Any One Else Living in the House Age 18 or Over
- ☐ **First Aid Certification** (For Anyone Providing Direct Care To Children)
- ☐ **Infant, Child, and Adult CPR Certification** (For Anyone Providing Direct Care To Children)
- ☐ **Out of State Background Checks** (must be fingerprint based)
- ☐ Yourself ☐ Your Spouse ☐ Any Additional Workers
- ☐ Any One Else Living in the House Age 18 or Over

Return Completed Packet To:

Bobbi Jo Walla
Child Care Licensing Program
848 Main Street #20
Billings, MT 59105

Phone: (406) 256-7062
Fax: (406) 256-7062